IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

July 24, 2006

FILE COPY

Josiah Dahlstrom, Administrator
Beacon Hospital of Pocatello
1200 Hospital Way
Pocatello, ID 83201

RE: Beacon Hospital of Pocatello Provider Number 134011

Dear Mr. Dahlstrom:

This is to advise you of the findings of the State Licensure and Medicare fire safety survey of Beacon Hospital of Pocatello conducted June 29, 2006.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing fire and life safety deficiencies that will require a Plan of Correction. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by August 3, 2006, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

Chris Laumann
Health Facility Surveyor
Facility Fire Safety & Construction

mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134011	A. BUILDING 02 - ENTIRE HOSPITAL INCLU B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON HOSPITAL OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, type V(111) construction with a large basement. The facility was originally built/completed on 6/1/1970. A refurbishment was completed in 2000. It is fully sprinklered and has complete smoke detection in corridors and open spaces. Currently it is licensed for 12 psychiatric hospital beds and 84 SNF/NF beds. The following deficiencies were cited during the annual Fire Life Safety survey conducted on 6/29/2006. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, adopted 3/11/2003.In accordenance with CFR 42 482.41 The survey was conducted by: Debra Ransom, RN, RHIT Team Leader Keith Barkow, Health Facility Surveyor Chris Laumann, Health Facility Surveyor	K 000		

RECEIVED
AUG 03 2006
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Josiah Dahlstrom	Administrator	8/2/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that there be no impediment to closing doors and that all resident doors close and latch as required by the Life Safety Code, 2000 Edition, Chapter 19.3.6.3. Findings includes: During the tour of the facility at 9:45 AM on June 29, 2006, room 12 was observered to have a door propped open with a box of latex gloves. This created an impediment to the door closing. This finding was acknowledged and noted by the	K 018	**K 018** Facility staff have been in-serviced on the need to not prop doors open. The administrator and director of nursing will monitor doors on a daily basis to ensure that doors are not propped open and will provide immediate training to staff if any are ever found.	08-03-06

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K 018	Continued From page 2 maintenance staff.	K 018	**K 147** 1-Two baseboard heating units had been removed at the time of the survey for the installation of new carpet. The wires were disconnected and exposed, but wire nuts had been placed over the ends of the wires and the corresponding breaker had been turned off. The carpet has been installed and the heaters have been replaced. There are no longer any exposed wires. 2- The extension cord in the library has been removed. The staff have been in-serviced identifying the problems listed above and the procedure to notify the maintenance department of problems.	08-03-06
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation the facility failed to snsure that there were no exposed wiring and no permenant use of extension cords . The facility had 12 beds with a census of 6 patients of whom all were effected. Findings included: 1. Two instances of exposed electrical wiring on the baseboard heating units were observed in the library and the connecting office at 10:20 AM on June 29, 2006. 2. One instance of permenant use of extension cords was observed in the library at 10:15 AM on June 29, 2006. NFPA 70, National Electrical Code. 9.1.2 states that extension cords are for temporary use only. All finding were observed and noted by survey team and maintenance supervisor.	K 147		